STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155319	A. BUILDING _____ B. WING _____	C 02/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF CLINTON THE	375 S 11TH ST CLINTON, IN 47842

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00084624 and IN00085086. Complaint IN00084624- Substantiated, deficiencies related to the allegations are cited at F223, F224, F225, and F226. Complaint IN00085086- Unsubstantiated due to lack of evidence. Survey dates: 2/3, 2/4, and 2/7/11 Facility number: 000212 Provider number: 155319 AIM number: 100285040 Survey team: Teresa Buske, RN /TC Mary Weyls, RN Laura Brashear, RN Census bed type: SNF/NF: 82 Total: 82 Census payor type: Medicare: 11 Medicaid: 55 Other: 16 Total: 82 Sample: 22 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on February 10, 2011 by Bev Faulkner, RN	F 000	Preparation and/or execution of this plan of correction, in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. RECEIVED FEB 28 2011 LONG TERM CARE DIVISION INDIANA STATE DEPARTMENT OF HEALTH ENTERED MAR 1 2011	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Staff Administrator	Administrator	02/25/2011

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 223 SS=D	483.13(b), 483.13(b)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure residents were free from physical abuse for 2 of 2 residents with allegations of staff abuse i.e. "rough care" and/or "my arm twisted" in a sample of 22. (Resident C, Resident F). Findings include: 1. During initial tour on 2/3/11 at 1:20 p.m., the Director of Nursing indicated Resident F was alert and oriented, utilized wheelchair propelling self, and was participating in therapy currently. On 2/3/11 at 2:30 p.m., documentation was noted from an investigation titled "Allegations of Abuse Checklist," dated 1/5/11, for Resident F provided by the Administrator. The documentation included "Report of Concern " form, dated 1/5/11, of "On Sunday 01/02, [CNA #10] had an altercation with [Resident F]. [Resident F] wanted her blanket, that was across the room. States [CNA #10] said she had a lot to do and was flickering her hands. Stated 'She had both of her arms on her right arm to take the call light away and my arm twisted.' 'She jerked her hand away and said Don't bite	F 223	It is the intent of this facility for all residents to be free from physical abuse. **1. CORRECTIVE ACTION:** CNA #10 was placed on an immediate suspension. A thorough investigation was completed, including interview of Resident F , other residents cared for by CNA #10, and staff members who have worked with and around CNA #10. The investigation revealed that there was no intentional harm placed by CNA #10, and CNA #10 did truly think Resident F was going to bite her. CNA #10 was provided with a directed inservice to patient care and stress. RN #4 had provided CNA #10 a written warning on 01/02/11. Due to a potential conflict, RN #4 removed CNA #10 from caring forResident F for the remainder of her shift. RN #4 was provided a inservice regarding the proper policy and procedure in relation to removing the staff member from complete duty until an investigation is complete. CNA #9 was suspended on 01/26/11 and was terminated from employment on 01/28/11. A thorough investigation began on 01/26/11, including interview of Resident C, other residents cared for by CNA #9, and other staff members who worked with and around CNA #9. Although, in the survey it revealed that CNA #7 stated this had also occurred in December. This information was not stated in the initial interview on 01/26/11. However, additional allegations and proper identification of CNA #9 concluded immediate termination of CNA #9 at the conclusion of the investigation. RN #5 had written the "Compliment and	

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F 223	Continued From page 2 me.' 'I don't know what made her think of such a thing.' 'Stated her arm felt sore but was fine and had no further complaints." Further documentation indicated the facility determined "there was no intentional abuse. The employee has no prior history nor has received any prior complaints. Resident [Resident F] states [CNA #10] grabbed her arm, CNA states resident grabbed her. CNA was in the process of positioning her in bed....[RN #4] performed write up on CNA [CNA #10] on 01/02/11 for verbal exchange however, on 01/05/11 [Resident F and daughter] came [and] added the touching of the arm and this report [and] investigation followed. [CNA #10 was suspended on 1/5/11 via telephone pending investigation." Interview of RN #4 on 2/4/11 at 1:40 p.m., indicated on 1/2/11 she was walking up the hallway and heard loud voices in Resident F's room. RN stated the resident was being put to bed and the door to the room was closed. The RN indicated she entered the room and asked what was going on to CNA #10. The resident stated she wanted her pink blanket which was on the dresser and CNA indicated the resident tried to bite her. The RN indicated she asked CNA #10 to leave and she finished putting Resident F to bed. The RN stated the resident indicated she was going to bring the incident to the Administrator's attention. RN #4 indicated she told the resident to do that and it was her right. The RN stated CNA #10 continued to work but was barred from Resident F's room. The RN stated no injury was noted to the resident. Interview of Resident F on 2/4/11 at 2:30 p.m., indicated she had concerns with CNA #10 on 1/2/11. The Resident indicated the CNA had	F 223	Concern Form" on 01/24/11. However, slid the form under the Administrator's office door and due to meetings out of the office, was picked up by the Administrator on 01/26/11. RN # 5 was reinserviced of the proper policies and procedures regarding immediate reporting to the Administrator/Director of Nurses of any allegations of abuse. in relation to removing the staff member from complete duty until an investigation is complete. **2. OTHERS IDENTIFIED:** Social Services completed a 100% audit on 02/08/11, of all residents and family's to determine if there were any other areas of concern. No other areas of concern were identified. **3. SYSTEMS IN PLACE:** An inservice was held on 2/07/11 and 2/08/11 for all staff to re-educate on current policies and procedures for allegations of abuse. Licensed nurses received additional training on the proper protocal of: dismiss employee from current shift; immediate notification of the Administrator/Director of Nurses; initiate investigation. **4. MONITORING:** The Administrator/Director of Nursing will monitor during weekly routine QA rounds to ensure all staff are aware of the proper policies and procedures and all immediate steps are properly conducted to ensure the safety of the residents. QA rounds will include random sampling of staff and residents to ensure residents are free from abuse.	

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F 223	Continued From page 3 yelled at her for two days (1/2/11 being day two). The resident indicated the CNA had "yelled" at her about everything and she was tired of it. So while the CNA was in the bathroom on 1/2/11 while assisting her to bed, the resident stated she told the CNA she was going to report her and picked up the call light to use. The resident stated the CNA came out of the bathroom and placed both of her hands on her right arm and took the call light away. The resident then stated the nurse came in and sent the CNA out. The resident stated the nurse told her to report it to the Administrator since it doesn't do them any good. The resident stated she did not have any bruises and then a few days later she and her daughter went to the Administrator to report CNA #10. The resident stated she has not had any issues with CNA #10 since that time and indicated the CNA continued to care for her. On 2/4/11 at 2:30 p.m., Resident F was observed to reposition self in bed. Review of the personnel file of CNA #10 on 2/4/11 at 2:20 p.m., indicated a written warning on 8/20/10 of Resident I with complaint of CNA being rude and rushing during care. A second written warning was noted, dated 1/2/11, of "This nurse walking by room [Resident F room] heard employee and resident loudly having disagreement over blanket and positioning. Heard employee say to resident 'don't bite me.' Resident states CNA attempting to take call light 'away from me.' Resident states CNA had removed her pink 'Snuggie' blanket. Blanket was across room on dresser." Review of the "timecard" of CNA #10 on 2/4/11 at 2:35 p.m., indicated CNA worked 1/2/11, 1/3/11,	F 223	All Grievance forms will immediately be presented to the Adm./Designee to determine if abuse of any type has occurred. All Grievances will be reviewed monthly with the QA team and quarterly at QA meeting with the Medical Director to ensure on-going compliance. **5. DATE COMPLETE:** This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is March 9, 2011.	

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F 223	Continued From page 4 and 1/4/11 on 7-3 shift. 2. A facility investigation of abuse was received on 2/3/11 at 2:30 p.m., from the Administrator. A "Compliment and Concern Form" was noted, dated 1/24/11. RN #5 documented a concern received by Resident C indicating "Resident states she does not trust staff member et (and) that she is too rough [with] her. She feels that she is always trying to butter people up. She requests to not have CNA #9 care for her." A form titled "Allegations of Abuse", dated 1/26/11, was noted. Written interviews of staff and residents were noted within the written investigation. CNA #7's documentation indicated "[CNA #9] had been rough with [Resident C]..." Documentation was noted that Resident C indicated CNA #9 was rough when changing the resident's colostomy bag in that the CNA pulled the resident's pants real hard "I cried". The resident indicated she had complained during a shower that CNA #9 had got soap in her eyes and CNA #9 sprayed her in the face with the hand sprayer. Documentation indicated Resident C requested that CNA #9 not be allow to care for her. During interview of CNA #7 on 2/4/11 at 2 p.m., the CNA indicated she had assisted CNA #9 while caring for Resident C sometime before Christmas. CNA #7 indicated CNA #9 grabbed Resident C's legs and roughly sat the resident up on the side of the bed. CNA #7 indicated the	F 223		

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F 223	Continued From page 5 resident stated "OH" and started crying. CNA #7 indicated she told CNA #9 she would finishing caring for Resident C. CNA #7 indicated she went to the charge nurse and reported she felt CNA #9 was rough with Resident C. CNA #7 indicated she could not remember the name of the charge nurse she had reported to. Resident C's clinical record was reviewed on 2/3/11 at 2:55 p.m. An annual assessment was noted, dated 1/1/11. The assessment indicated the resident was interviewable requiring assist with bed mobility, transfers and hygiene/bathing. Review of facility current policy and procedure titled "Abuse-Response to Suspected" dated 6/1/10 on 2/4/11 at 1:40 p.m., indicated "Policy: It is the intent of this facility to maintain an environment free of abuse and neglect. The resident had the right to be free from verbal, sexual, physical , and mental abuse, corporal punishment, involuntary seclusion, and misappropriation of their property (collectively, sometimes referred to as 'events.)' ...Identification of abuse can occur in several ways. Witness Report/Complaints: All allegations of abuse must be taken seriously and must be investigated. The reporting and investigation policies and procedures must be fully enforced... 2. If the allegation is related to physical , verbal, or mental abuse of a resident, the Administrator , designee, or staff member present at the time of the allegation will take immediate steps to prevent further potential abuse while the investigation is in progress..."	F 223		

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F 223	Continued From page 6 This Federal tag relates to Complaint IN00084624. 3.1-27(a)(1)	F 223		
F 224 SS=E	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure residents were free of having their property taken without their consent for 5 of 5 residents reviewed with allegations of missing property in a sample of 22. [Residents A, B, D, E, and G] Findings include: 1. During initial tour with LPN #1, on 2/3/11 at 1:00 p.m., Resident A was identified as alert and oriented. At that time, Resident A was interviewed. Resident A indicated about three months ago she had $65.00 missing from a drawer in her room. The resident indicated no one enters her room other than nursing staff and housekeeping staff. The resident indicated she had notified the Administrator and Social Service Director. Resident A's clinical record was reviewed on 2/3/11 at 2:00 p.m. The most recent Minimum	F 224	It is the intent of this facility to ensure residents were free of having their property taken without their consent. **1. CORRECTIVE ACTION:** Although the items were always replaced when not located, and a thorough investigation was conducted for each occurrence. The investigations did not reveal a suspect. **2. OTHERS IDENTIFIED:** Social Services conducted a 100% audit of all residents for any other concerns with missing property which was completed on 02/08/11. No other residents identified. **3. SYSTEMS IN PLACE:** An in-service was held on 2/07/11 and 02/08/11 for all staff to re-educate on current policies and procedures for residents who have property taken without their consent. **4. MONITORING:** The Administrator/Director of Nursing will monitor during weekly routine QA rounds to ensure all staff are aware of the proper policies and procedures and steps taken if a resident has property taken without their consent. QA rounds will include a random sampling of staff and residents. Any/All Missing property reports will be immediately given to the Administrator for follow-up, investigation, and resolution.	

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F 224	Continued From page 7 Data Set [MDS] assessment, completed on 11/29/10, assessed the resident with no cognition impairments. On 2/3/11 at 2:30 p.m., the Administrator was interviewed. The Administrator indicated the resident was alert and oriented. The Administrator indicated the facility verified $50.00 was missing and it was replaced on 1/5/11. The Administrator indicated they thought it was a staff member who had taken the money, but could not identify any certain staff member who might have done it. A form titled "Complaint/Grievance Form," dated 4/08, completed on 11/20/10, addressed the concern of "$50 missing from hidden spot. [Resident A]. It was there Thurs. [11/18/10], she didn't look Friday [11/19/10] but it was gone after lunch [11/20/10] today." Documentation on the form addressed Action Taken ...interview of staff who worked on the resident's wing on 11/19, and 20/10. A notation was made of CNAs/staff individually interviewed and the Resident's family conferred the money had been there. On 2/4/11 at 12:00 p.m., the Director of Nursing (DON) was interviewed. The DON indicated during the investigation the only resident interviewed was Resident A's roommate. 2. On 2/3/11 at 3:35 p.m., RN #3 was interviewed. The RN indicated Resident D had reported missing money, which was reported to the DON and Social Service Director [SSD]. RN #3 indicated she thought it was in November or December.	F 224	All Missing Property Reports will be reviewed at the monthly QA meeting and at the quarterly QA meeting with the Medical Director to ensure on-going compliance. **5. DATE COMPLETE:** This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is March 9, 2011.	

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F 224	Continued From page 8 Resident D was interviewed on 2/4/11 at 10:15 a.m. The resident indicated she had not had money missing but had a bottle of liquid body soap and two new Suave deodorant sticks that she had personally purchased missing. The resident indicated she had reported it to the SSD and thought she had looked into it. On 2/4/11 at 4:00 p.m. the SSD was interviewed. The SSD indicated she didn't know anything about it. 3. On 2/4/11 at 12:45 p.m., the Administrator was interviewed regarding reports of concern. The Administrator indicated that on 11/9/10 there was a report made by Resident E's daughter of the resident having a bottle of Olay Body Lotion missing. The Administrator indicated the resident's room was searched and the facility was unable to locate the lotion. The Administrator indicated the lotion was replaced on 11/18/10. 4. During initial tour on 2/3/11 which began at 2:05 p.m., with LPN #20, LPN #20 indicated Resident B was alert and oriented. A facility investigation of abuse was received on 2/3/11 at 2:30 p.m., from the Administrator. The investigation indicated Resident B was interviewed on 1/26/11. Documentation indicated the resident indicated, "I have had candy and pop taken by 'sticky fingers, (CNA #9). Also lotion and talcum powder taken. My roommate had pop taken from her and I have seen her get in her refrigerator, take out the bottle of cranberry juice, drink it and put it back." During interview of Resident B on 2/4/11 at 11:15	F 224		

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F 224	Continued From page 9 a.m., Resident B indicated she has had talcum powder, lotion and candy missing. The resident indicated she had seen CNA #9 take candy out of her bedside drawer. The resident indicated she had seen CNA #9 take items from her roommate, such as cans of coke. Resident B indicated she had seen CNA #9 take a drink out of a bottle of Resident H's [roommate] cranberry juice and put the cap back on the bottle. The resident indicated she had told staff about CNA #9's behavior. During interview of RN #3 on 2/3/11 at 3:35 p.m., the RN indicated that Resident B had told her about CNA #9 taking items from her (Resident B) and Resident H. RN #3 indicated she told Resident B she should tell someone higher than me (RN #3). Resident B's clinical record was reviewed on 2/4/11 at 11 a.m. An annual assessment, dated 11/09/10, indicated the resident as interviewable. 5. During initial tour on 2/3/11 which began at 1:15 p.m., with LPN #20, LPN #20 indicated Resident G was alert and oriented. During interview of Resident G on 2/3/11 at 2:05 p.m., the resident indicated she goes out to visit family every other week. The resident indicated when she would return back to the facility she would have candy or lotion missing. The resident indicated she told her family to just stop bringing her candy. The resident indicated when she first came to the facility "they" told her not to keep money in her room. During interview of RN #4 on 2/4/11 at 1:40 p.m., RN #4 indicated Resident G came out of her room one day and was mad. The RN indicated	F 224		

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F 224	Continued From page 10 the resident was upset because a half of bottle of lotion was missing. RN #4 indicated she worked weekend option, so she wrote a note concerning the missing lotion and put it under the door of the DON (Director of Nursing). Review of facility current policy and procedure titled "Abuse-Response to Suspected," dated 6/1/10, on 2/4/11 at 1:40 p.m., indicated "Policy: It is the intent of this facility to maintain an environment free of abuse and neglect. The resident had the right to be free from verbal, sexual, physical , and mental abuse, corporal punishment, involuntary seclusion, and misappropriation of their property (collectively, sometimes referred to as 'events.)' ...Identification of abuse can occur in several ways. Witness Report/Complaints: All allegations of abuse must be taken seriously and must be investigated. The reporting and investigation policies and procedures must be fully enforced. Based on findings during the investigation, a final conclusion about the alleged abuse can be determined...Step 1 Any alleged violation involving mistreatment, misappropriation of property, abuse, neglect, or exploitation of a resident shall be immediately reported to the Administrator, Director of Nursing or designee(s). Additionally , any person may report such an event, and everyone is encouraged to report observations that suggest an event has occurred. ..3...If reasonable cause exists to believe an event occurred, the Administrator is responsible to report to the Indiana State Department of Health as per the reporting guidelines...5. The Administrator or designee shall thoroughly investigate all allegations of an event...7. If the suspected perpetrator is an employee of the facility, he/she will be suspended until the	F 224		

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F 224	Continued From page 11 investigation has been completed...9. The Director of Nursing shall ensure the Incident Documentation and Investigation Tool regarding the event is completed unless the event is suspected misappropriation of resident property for which you must use the Misappropriation of Property Investigation Report...12. Results of the investigation related to the resident's incident shall be reported to the Department of Health officials as soon as reasonably possible, in accordance with State and Federal Law..." Review of facility current policy and procedure titled "Reportable Unusual Occurrences," dated 4/1/06, on 2/4/11 at 1:40 p.m., indicated "... Procedure: Occurrences to be reported: Facilities are required by law to report unusual occurrences within 24 hours of occurrence to the Long Term Care Division CFR 483.13(c)(2) states that 'the facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State Law through established procedures (including to the State Survey and Certification Agency." Review of facility current policy and procedure titled "Abuse Prohibition," dated 6/1/10, on 2/4/11 at 1:40 p.m., indicated "...Misappropriation of Resident Property : The deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent..." This Federal tag relates to Complaint IN00084624.	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155319	A. BUILDING _____ B. WING _____	C 02/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF CLINTON THE	375 S 11TH ST CLINTON, IN 47842

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F 224	Continued From page 12 3.1-28(a)	F 224		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225	It is the intent of this facility that all alleged violations of physical abuse and/or misappropriation of resident property are immediately reported to the administrator or other officials, allegations are thoroughly investigated and further potential abuse is prevented. **1. CORRECTIVE ACTION:** An in-service was held on 2/07/11 and 02/08/11, for all staff, to re-educate on current policies and procedures for any/all allegations of abuse and/or misappropriation of resident property, which included: protecting the resident by removing the person allegations are made against, immediately reporting to Administrator/Designee, thorough investigation of all staff/residents involved. **2. OTHERS IDENTIFIED:** Social Service will conduct interviews with all resident/family members to identify any further complaints of abuse and/or missing property. No other residents identified. **3. SYSTEMS IN PLACE:** All employees' were in-serviced on 2/07/11 and 2/08/11 and each new hire will receive Abuse training prior to employment. In-Service included: Current Policies and procedures for allegations of abuse and misappropriation of resident property, protection of the resident, immediate reporting, thorough investigation of all staff/residents involved and prevention of misappropriation of resident property and any type/kind of abuse.	

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F 225	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure all alleged violations of physical abuse and/or misappropriation of resident property for 7 of 7 residents with allegations of physical abuse and/or misappropriation of their property i.e. missing property in a sample of 22; in that, 1) the allegations were not reported immediately to the administrator or other officials (ISDH); 2) allegations were not thoroughly investigated as all staff involved were not interviewed and/or other residents were not interviewed and, 3) further potential abuse was not prevented during investigations as staff with allegations were allowed to work after the allegations were voiced by residents. (Residents C, B, G, A , D, E, F) Findings include: 1. During initial tour on 2/3/11 at 1:20 p.m., the Director of Nursing indicated Resident F was alert and oriented, utilized wheelchair propelling self, and participating in therapy currently. On 2/3/11 at 2:30 p.m., documentation was noted from an investigation titled "Allegations of Abuse Checklist," dated 1/5/11, for Resident F provided by the Administrator. The documentation included "Report of Concern" form, dated 1/5/11, of "On Sunday 01/02, [CNA #10] had an altercation with [Resident F]. [Resident F] wanted her blanket, that was across the room. States [CNA #10] said she had a lot to do and was flickering her hands. Stated 'She had both of her arms on her right arm to take the call light away and my arm twisted.'	F 225	**4. MONITORING:** The Administrator/Director of Nursing will monitor during weekly routine QA rounds to ensure all staff are aware of the proper policies and procedures and appropropriate steps are taken for allegations. ADM/Designee will monitor/review all allegations of any suspected abuse and/or Misappropriation of resident property, as any occur, each am during the morning QA stand-up meeting to ensure facility policy/procdures are being followed. ADM/Designee will review all allegations of abuse And misappropriation of resident property at the monthly QA Meeting with the IDT; and quarterly at the QA meeting with the Medical Director. **5. DATE COMPLETE:** This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is March 9, 2011.	

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F 225	Continued From page 14 'She jerked her hand away and said Don't bite me.' 'I don't know what made her think of such a thing.' 'Stated her arm felt sore but was fine and had no further complaints." Further documentation indicated the facility determined "there was no intentional abuse. The employee has no prior history no has received any prior complaints. Resident [Resident F] states [CNA #10] grabbed her arm, CNA states resident grabbed her. CNA was in the process of positioning her in bed....[RN #4] performed write up on CNA [CNA #10] on 01/02/11 for verbal exchange however, on 01/05/11 [Resident F and daughter] came [and] added the touching of the arm and this report [and] investigation followed. [CNA #10 was suspended on 1/5/11 via telephone pending investigation." Interview of RN #4 on 2/4/11 at 1:40 p.m., indicated on 1/2/11 she was walking up the hallway and heard loud voices in Resident F's room. RN stated the resident was being put to bed and the door to the room was closed. The RN indicated she entered the room and asked what was going on to CNA #10. The resident stated she wanted her pink blanket which was on the dresser and the CNA indicated the resident tried to bite her. The RN indicated she asked CNA #10 to leave and she finished putting Resident F to bed. The RN stated the resident indicated she was going to bring the incident to the Administrator's attention. RN #4 indicated she told the resident to do that and it was her right. The RN stated CNA #10 continued to work but was barred from Resident F's room. The RN stated no injury was noted to the resident. The RN stated she wrote a written warning on 1/2/11 regarding verbal response of CNA #10 to Resident F and that CNA #10 signed it on 1/2/11.	F 225		

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F 225	Continued From page 15 The RN also indicated she wrote on a nursing note the concerns of CNA #10 with Resident F on a nursing note and placed it under the Director of Nursing's office door. The RN did not notify the Director of Nursing or the Administrator regarding the allegation of Resident F concerning CNA #10. The RN indicated no administrative staff talked to her regarding incident with CNA #10 and Resident F. Interview of Resident F on 2/4/11 at 2:30 p.m., indicated she had concerns with CNA #10 on 1/2/11. The Resident indicated the CNA had yelled at her for two days (1/2/11 being day two). The resident indicated the CNA had "yelled" at her about everything and she was tired of it. So while the CNA was in the bathroom on 1/2/11 while assisting her to bed, the resident stated she told the CNA she was going to report her and picked up the call light to use. The resident stated the CNA came out of the bathroom and placed both of her hands on her right arm and took the call light away. The resident then stated the nurse came in and sent the CNA out. The resident stated the nurse told her to report it to the Administrator since it doesn't do them any good. The resident stated she did not have any bruises and then a few days later she and her daughter went to the Administrator to report CNA #10. The resident stated she has not had any issues with CNA #10 since that time and indicated the CNA continued to care for her. Interview of the Administrator on 2/3/11 at 2:30 p.m., indicated the allegation and investigation of CNA #10 and Resident F had not been reported to ISDH and that she was unaware of the allegation until 1/5 11 when Resident F and her daughter came to her with the allegation.	F 225		

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F 225	Continued From page 16 Interview of the Director of Nursing on 2/4/11 at 4:55 p.m., indicated she was unaware of allegation with Resident F until 1/5/11 and that the written verbal warning may have been in her office on 1/2/11 but that she was unaware. Review of the personnel file of CNA #10 on 2/4/11 at 2:20 p.m., indicated a written warning on 8/20/10 of Resident I with complaint of CNA being rude and rushing during care. A second written warning was noted, dated 1/2/11, of "This nurse walking by room [Resident F room] heard employee and resident loudly having disagreement over blanket and positioning. Heard employee say to resident 'don't bite me.' Resident states CNA attempting to take call light 'away from me.' Resident states CNA had removed her pink 'Snuggie' blanket. Blanket was across room on dresser." Review of the "timecard" of CNA #10 on 2/4/11 at 2:35 p.m., indicated the CNA worked 1/2/11, 1/3/11, and 1/4/11 on 7-3 shift. 2. A facility investigation of abuse was received on 2/3/11 at 2:30 p.m., from the Administrator. A "Compliment and Concern Form" was noted, dated 1/24/11. RN #5 documented a concern received by Resident C indicating 'Resident states she does not trust staff member et (and) that she is too rough [with] her. She feels that she is always trying to butter people up. She requests to not have [CNA #9] care for her.' During interview of RN #5, on 2/3/11 at 3:15 p.m., the RN indicated she had filled out the "Compliment and Concern Form" after Resident C had made an allegation against CNA #9. The	F 225		

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F 225	Continued From page 17 RN indicated she gave the form to the DON on 1/24/11. During interview of the Administrator on 2/3/11 at 3 p.m., the Administrator indicated she was not aware of the allegations of mistreatment made against CNA #9 until two days later on, 1/26/11. The Administrator indicated she implemented an investigation concerning Resident C's allegation against CNA #9 on 1/26/11 . The Administrator indicated CNA #9 worked the day shift on 1/26/11, but did not work with Resident C. The Administrator indicated CNA #9 was suspended at the end of her shift at 3 p.m., once the allegation had been substantiated. The Administrator indicated the State Department of Health had not been notified of the allegation of mistreatment. During interview of the DON (Director of Nursing) on 2/3/11, at 3 p.m. The DON indicated she was not aware of the allegation made against CNA #9 until 1/26/11. 3. A facility investigation of abuse was received on 2/3/11 at 2:30 p.m., from the Administrator. The investigation indicated Resident B was interviewed on 1/26/11. Documentation indicated the resident indicated, "I have had candy and pop taken by 'sticky fingers, (CNA #9). Also lotion and talcum powder taken. My roommate had pop taken from her and I have seen her (CNA#9) get in her refrigerator, take out the bottle of cranberry juice, drink it and put it back." During interview of RN #3 on 2/3/11 at 3:35 p.m., the RN indicated that Resident B had told her about CNA #9 taking items from her (Resident B) and Resident H. RN #3 indicated she told	F 225		

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F 225	Continued From page 18 Resident B she should tell someone higher than me (RN #3). During interview of the Administrator on 2/3/11, at 3 p.m., the Administrator indicated she had not reported the allegation of missing property to the Indiana State Department of Health. The Administrator indicated the allegation was found on 1/26/11 during investigation of allegation regarding Resident C. 4. During interview of Resident G on 2/3/11 at 2:05 p.m., the resident indicated she goes out to visit family every other week. The resident indicated when she would return back to the facility she would have candy or lotion missing. The resident indicated she told her family to just stop bringing her candy. The resident indicated when she first came to the facility "they" told her not to keep money in her room. During interview of RN #4 on 2/4/11 at 1:40 p.m., RN #4 indicated Resident G came out of her room one day and was mad. The RN indicated the resident was upset because a half of bottle of lotion was missing. RN #4 indicated she worked weekend option, so she wrote a note concerning the missing lotion and put it under the door of the DON (Director of Nursing). During interview of the DON and Administrator on 2/3/11 at 3 p.m., the DON and Administrator were not aware of the allegations of missing items. 5. During initial tour with LPN #1, on 2/3/11 at 1:00 p.m., Resident A was identified as alert and oriented. At that time, Resident A was interviewed. Resident A indicated about three months ago she had $65.00 missing from a	F 225		

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F 225	Continued From page 19 drawer in her room. The resident indicated no one enters her room other than nursing staff and housekeeping staff. The resident indicated she had notified the Administrator and Social Service Director. Resident A's clinical record was reviewed on 2/3/11 at 2:00 p.m. The most recent Minimum Data Set [MDS] assessment, completed on 11/29/10, coded the resident with no cognition impairments. On 2/3/11 at 2:30 p.m., the Administrator was interviewed. The Administrator indicated the resident was alert and oriented. The Administrator indicated the facility verified $50.00 was missing and it was replaced on 1/5/11. The Administrator indicated they thought it was a staff member who had taken the money, but could not identify any certain staff member who might have done it. The Administrator indicated the Indiana State Department of Health was not notified of the missing money. A form titled "Complaint/Grievance Form," dated 4/08, completed on 11/20/10, addressed the concern of "$50 missing from hidden spot. [Resident A]. It was there Thurs. [11/18/10], she didn't look Friday [11/19/10] but it was gone after lunch [11/20/10] today. Documentation on the form addressed Action Taken ...interview of staff who worked on the resident's wing on 11/19, and 20/10. A notation was made of CNAs/staff individually interviewed and the resident's family conferred the money had been there. On 2/4/11 at 12:00 p.m., the DON was	F 225		

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F 225	Continued From page 20	F 225		

interviewed. The DON indicated during the investigation the only resident interviewed was Resident A's roommate.

6. On 2/3/11 at 3:35 p.m., RN #3 was interviewed. The RN indicated Resident D had reported missing money, which was reported to the DON and Social Service Director [SSD]. RN #3 indicated she thought it was in November or December.

Resident D was interviewed on 2/4/11 at 10:15 a.m. The resident indicated she had not had money missing but had a bottle of liquid body soap and two new Suave deodorant sticks that she had personally purchased missing. The resident indicated she had reported it to the SSD and thought she had looked into it.

On 2/4/11 at 4:00 p.m. the SSD was interviewed. The SSD indicated she didn't know anything about it.

Review of the clinical record of Resident D on 2/4/11 at 10:05 a.m. indicated the most recent Minimum Data Set (MDS) assessment was completed 12/3/10. The assessment identified no impairment in cognition.

7. On 2/4/11 at 12:45 p.m., the Administrator was interviewed regarding reports of concern. The Administrator indicated that on 11/9/10 there was a report made by Resident E's daughter of the resident having a bottle of Olay Body Lotion missing. The Administrator indicated the investigation included a search of the resident's room and the facility was unable to locate the lotion. The Administrator indicated the lotion was replaced on 11/18/10. The Administrator indicated

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F 225	Continued From page 21 Indiana State Department of Health was not notified of the missing lotion and replacement of the lotion. On 2/7/11 at 12:05 p.m., the Administrator was interviewed. The Administrator indicated the form titled "Compliment and Concern Form" was implemented 11/1/10. The Administrator indicated the forms were located throughout the facility for residents, families, staff, etc. to complete and give to a staff member or place under her door of any concerns. The Administrator indicated she was responsible for following up on the concerns. The Administrator indicated since implementation of the form, she had not delegated any concerns to other staff for review. This Federal tag relates to Complaint IN00084624. 3.1-28(c) 3.1-28(d) 3.1-28(e)	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to implement written policies and procedures for abuse of residents and misappropriation of resident property for 7 of 7	F 226	It is the intent of the facility to implement written policies and procedures for suspected abuse of residents and misappropriation of resident property; by immediately reporting the occurrence to the ADM/Designee, by a thorough investigation of all staff/residents involved, and prevention of potential further abuse during investigations by not allowing staff with allegations to work until the investigation has been completed and resolution has been obtained.	

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F 226	Continued From page 22 residents with allegations of physical abuse and/or missing of property in a sample of 22; in that, 1) the allegations were not reported immediately to the administrator or other officials (ISDH); 2) allegations were not thoroughly investigated as all staff involved were not interviewed and/or other residents were not interviewed and 3) further potential abuse was not prevented during investigations as staff with allegations were allowed to work after the allegations were voiced by residents. (Residents C, B, G, A , D, E ,F) Findings include: 1. During initial tour on 2/3/11 at 1:20 p.m., the Director of Nursing indicated Resident F was alert and oriented, utilized a wheelchair, propelled self, and was participating in therapy currently. On 2/3/11 at 2:30 p.m., documentation was noted from investigation titled "Allegations of Abuse Checklist," dated 1/5/11, for Resident F provided by the Administrator. The documentation included "Report of Concern " form, dated 1/5/11, of "On Sunday 01/02 , [CNA #10] had an altercation with [Resident F]. [Resident F] wanted her blanket, that was across the room. States [CNA #10] said she had a lot to do and was flickering her hands. Stated 'She had both of her arms on her right arm to take the call light away and my arm twisted.' 'She jerked her hand away and said Don't bite me.' 'I don't know what made her think of such a thing.' 'Stated her arm felt sore but was fine and had no further complaints." Further documentation indicated the facility determined "there was no intentional abuse. The employee has no prior history no has received any prior complaints. Resident [Resident F] states [CNA	F 226	**1. CORRECTIVE ACTION:** An in-service was held on 2/07/11 and 02/08/11 for all staff to educate on current policies and procedures for any type of Abuse and misappropriation of resident property; which included immediately reporting to the ADM/Designee, thorough investigation of all staff/residents involved and prevention of potential further abuse during investigations, by staff not working who have had an allegations made. **2. OTHERS IDENTIFIED:** Social Services will complete 100% interview of all residents/family's to identify any other allegations of abuse or misappropriation of resident property. No other residents identified. **3. SYSTEMS IN PLACE:** Every employee has been reinserviced 02/07 and 02/08/11 and each new hire receives the training prior to employment. Policies and procedures of allegations of any type of abuse and misappropriation of resident property, immediately reporting to ADM/Designee, thorough investigation of all staff/residents involved and prevention of potential further abuse during investigations, by staff not working if allegations are mad against them until investigation is complete.	

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WATERS OF CLINTON THE	375 S 11TH ST CLINTON, IN 47842

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 23 #10] grabbed her arm, CNA states resident grabbed her. CNA was in the process of positioning her in bed....[RN #4] performed write up on CNA [CNA #10] on 01/02/11 for verbal exchange however, on 01/05/11 [Resident F and daughter] came [and] added the touching of the arm and this report [and] investigation followed. [CNA #10 was suspended on 1/5/11 via telephone pending investigation." Interview of RN #4 on 2/4/11 at 1:40 p.m., indicated on 1/2/11 she was walking up the hallway and heard loud voices in Resident F's room. RN #4 stated the resident was being put to bed and the door to the room was closed. The RN indicated she entered the room and asked what was going on to CNA #10. The resident stated she wanted her pink blanket which was on the dresser and CNA indicated the resident tried to bite her. The RN indicated she asked CNA #10 to leave and she finished putting Resident F to bed. The RN stated the resident indicated she was going to bring the incident to the Administrator's attention. RN #4 indicated she told the resident to do that and it was her right. The RN stated CNA #10 continued to work but was barred from Resident F's room. The RN stated no injury was noted to the resident. The RN stated she wrote a written warning on 1/2/11 regarding verbal response of CNA #10 to Resident F and that CNA #10 signed it on 1/2/11. The RN also indicated she wrote on a nursing note the concerns of CNA #10 with Resident F on a nursing note and placed it under the Director of Nursing's office door. The RN did not notify the Director of Nursing or the Administrator regarding the allegation of Resident F concerning CNA #10. The RN indicated no administrative staff talked to her regarding incident with CNA #10 and	F 226	**4. MONITORING:** The Administrator/Director of Nursing will monitor during weekly routine QA rounds to ensure all staff are aware of the proper policies and procedures and appropropriate steps are taken for allegations. ADM/Designee will review all allegations of abuse and misappropriations of property as they occur to ensure protection of the resident and the immediate investigation is initiated. ADM/Designee will review all allegations Of abuse and misappropriations of property In monthly QA meeting with IDT and in the Quarterly QA meeting with the Medical Director to ensure on-going compliance. **5. DATE COMPLETE:** This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is March 9, 2011.	

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F 226	Continued From page 24 Resident F. Interview of Resident F on 2/4/11 at 2:30 p.m., indicated she had concerns with CNA #10 on 1/2/11. The Resident indicated the CNA had yelled at her for two days (1/2/11 being day two). The resident indicated the CNA had "yelled" at her about everything and she was tired of it. So while the CNA was in the bathroom on 1/2/11 while assisting her to bed, the resident stated she told the CNA she was going to report her and picked up the call light to use. The resident stated the CNA came out of the bathroom and placed both of her hands on her right arm and took the call light away. The resident then stated the nurse came in and sent the CNA out. The resident stated the nurse told her to report it to the Administrator since it doesn't do them any good. The resident stated she did not have any bruises and then a few days later she and her daughter went to the Administrator to report CNA #10. The resident stated she has not had any issues with CNA #10 since that time and indicated the CNA continued to care for her. Interview of the Administrator on 2/3/11 at 2:30 p.m., indicated the allegation and investigation of CNA #10 and Resident F had not been reported to ISDH and that she was unaware of the allegation until 1/5/11 when Resident F and her daughter came to her with the allegation. Interview of the Director of Nursing on 2/4/11 at 4:55 p.m., indicated she was unaware of allegation with Resident F until 1/5/11 and that the written verbal warning may have been in her office on 1/2/11 but that she was unaware. Review of the personnel file of CNA #10 on	F 226		

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F 226	Continued From page 25 2/4/11 at 2:20 p.m., indicated a written warning on 8/20/10 of Resident I with complaint of CNA being rude and rushing during care. A second written warning was noted, dated 1/2/11, of "This nurse walking by room [Resident F room] heard employee and resident loudly having disagreement over blanket and positioning. Heard employee say to resident 'don't bite me.' Resident states CNA attempting to take call light 'away from me.' Resident states CNA had removed her pink 'Snuggie' blanket. Blanket was across room on dresser." Review of the "timecard" of CNA #10 on 2/4/11 at 2:35 p.m. indicated the CNA worked 1/2/11, 1/3/11, and 1/4/11 on 7-3 shift. 2. A facility investigation of abuse was received on 2/3/11 at 2:30 p.m., from the Administrator. A "Compliment and Concern Form" was noted, dated 1/24/11. RN #5 documented a concern received by Resident C indicating "Resident states she does not trust staff member et (and) that she is too rough [with] her. She feels that she is always trying to butter people up. She requests to not have [CNA #9] care for her." During interview of RN #5, on 2/3/11 at 3:15 p.m., the RN indicated she had filled out the "Compliment and Concern Form" after Resident C had made an allegation against CNA #9. The RN indicated she gave the form to the DON. During interview of the Administrator on 2/3/11 at 3 p.m., the Administrator indicated she was not aware of the allegations of mistreatment made against CNA #9 until two days later on 1/26/11. The Administrator indicated she implemented an investigation concerning Resident C's allegation	F 226		

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F 226	Continued From page 26 against CNA #9 on 1/26/11. The Administrator indicated CNA #9 worked the day shift on 1/26/11, but did not work with Resident C. The Administrator indicated CNA #9 was suspended at the end of her shift at 3 p.m., once the allegation had been substantiated. The Administrator indicated the State Department of Health had not been notified of the allegation of mistreatment. 3. A facility investigation of abuse was received on 2/3/11 at 2:30 p.m., from the Administrator. The investigation indicated Resident B was interviewed on 1/26/11. Documentation indicated the resident indicated, "I have had candy and pop taken by 'sticky fingers, (CNA #9). Also lotion and talcum powder taken. My roommate had pop taken from her and I have seen her (CNA#9) get in her refrigerator, take out the bottle of cranberry juice, drink it and put it back." During interview of RN #3 on 2/3/11 at 3:35 p.m., the RN indicated that Resident B had told her about CNA #9 taking items from her (Resident B) and Resident H. RN #3 indicated she told Resident B she should tell someone higher than me (RN #3). During interview of the Administrator on 2/3/11, at 3 p.m., the Administrator indicated she had not reported the allegation of missing property to the Indiana State Department of Health. The Administrator indicated the allegation was found on 1/26/11 during investigation of allegation regarding Resident C. 4. During interview of Resident G on 2/3/11 at 2:05 p.m., the resident indicated she goes out to	F 226		

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F 226	Continued From page 27 visit family every other week. The resident indicated when she would return back to the facility she would have candy or lotion missing. The resident indicated she told her family to just stop bringing her candy. During interview of RN #4 on 2/4/11 at 1:40 p.m., RN #4 indicated Resident G came out of her room one day and was mad. The RN indicated the resident was upset because a half of bottle of lotion was missing. RN #4 indicated she worked weekend option, so she wrote a note concerning the missing lotion and put it under the door of the DON (Director of Nursing). During interview of the DON and Administrator on 2/3/11 at 3 p.m., the DON and Administrator were not aware of the allegations of missing items. 5. During initial tour with LPN #1, on 2/3/11 at 1:00 p.m., Resident A was identified as alert and oriented. At that time, Resident A was interviewed. Resident A indicated about three months ago she had $65.00 missing from a drawer in her room. The resident indicated no one enters her room other than nursing staff and housekeeping staff. The resident indicated she had notified the Administrator and Social Service Director. Resident A's clinical record was reviewed on 2/3/11 at 2:00 p.m. The most recent Minimum Data Set [MDS] assessment completed on 11/29/10, coded the resident with no cognition impairments. On 2/3/11 at 2:30 p.m., the Administrator was interviewed. The Administrator indicated the resident was alert and oriented. The Administrator indicated the facility verified $50.00	F 226		

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F 226	Continued From page 28 was missing and it was replaced on 1/5/11. The Administrator indicated they thought it was a staff member who had taken the money, but could not identify any certain staff member who might have done it. The Administrator indicated the Indiana State Department of Health was not notified of the missing money. A form titled "Complaint/Grievance Form," dated 4/08, completed on 11/20/10, addressed the concern of "$50 missing from hidden spot. [Resident A]. It was there Thurs. [11/18/10], she didn't look Friday [11/19/10] but it was gone after lunch [11/20/10] today. Documentation on the form addressed Action Taken ...interview of staff who worked on the resident's wing on 11/19, and 20/10. A notation was made of CNAs/staff individually interviewed and the resident's family confirmed the money had been there. On 2/4/11 at 12:00 p.m., the DON was interviewed. The DON indicated during the investigation the only resident interviewed was Resident A's roommate. 6. On 2/3/11 at 3:35 p.m., RN #3 was interviewed. The RN indicated Resident D had reported missing money, which was reported to the DON and Social Service Director [SSD]. RN #3 indicated she thought it was in November or December. Resident D was interviewed on 2/4/11 at 10:15 a.m. The resident indicated she had not had money missing but had a bottle of liquid body soap and two new Suave deodorant sticks that she had personally purchased missing. The	F 226		

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F 226	Continued From page 29 resident indicated she had reported it to the SSD and thought she had looked into it. On 2/4/11 at 4:00 p.m. the SSD was interviewed. The SSD indicated she didn't know anything about it. Review of the clinical record of Resident D on 2/4/11 at 10:05 a.m. indicated the most recent Minimum Data Set (MDS) assessment was completed 12/3/10. The assessment identified no impairment in cognition. 7. On 2/4/11 at 12:45 p.m., the Administrator was interviewed regarding reports of concern. The Administrator indicated that on 11/9/10 there was a report made by Resident E's daughter of the resident having a bottle of Olay Body Lotion missing. The Administrator indicated the resident's room was searched and the facility was unable to locate the lotion. The Administrator indicated the lotion was replaced on 11/18/10. The Administrator indicated Indiana State Department of Health was not notified of the missing lotion and replacement of the lotion. On 2/7/11 at 12:05 p.m., the Administrator was interviewed. The Administrator indicated the form titled "Compliment and Concern Form" was implemented 11/1/10. The Administrator indicated the forms were located throughout the facility for residents, families, staff, etc. to complete and give to a staff member or place under her door of any concerns. The Administrator indicated she was responsible for following up on the concerns. The Administrator indicated since implementation of the form, she had not delegated any concerns to other staff for review.	F 226		

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F 226	Continued From page 30 Review of facility current policy and procedure titled "Abuse-Response to Suspected," dated 6/1/10 on 2/4/11 at 1:40 p.m., indicated "Policy: It is the intent of this facility to maintain an environment free of abuse and neglect. The resident had the right to be free from verbal, sexual, physical , and mental abuse, corporal punishment, involuntary seclusion, and misappropriation of their property (collectively, sometimes referred to as 'events.)' ...Identification of abuse can occur in several ways. Witness Report/Complaints: All allegations of abuse must be taken seriously and must be investigated. The reporting and investigation policies and procedures must be fully enforced. Based on findings during the investigation, a final conclusion about the alleged abuse can be determined...Step 1 Any alleged violation involving mistreatment, misappropriation of property, abuse, neglect, or exploitation of a resident shall be immediately reported to the Administrator, Director of Nursing or designee(s). Additionally , any person may report such an event, and everyone is encouraged to report observations that suggest an event has occurred. 2. If the allegation is related to physical , verbal, or mental abuse of a resident, the Administrator , designee, or staff member present at the time of the allegation will take immediate steps to prevent further potential abuse while the investigation is in progress...3...If reasonable cause exists to believe an event occurred, the Administrator is responsible to report to the Indiana State Department of Health as per the reporting guidelines...5. The Administrator or designee shall thoroughly investigate all allegations of an event...7. If the suspected perpetrator is an employee of the facility, he/she will be suspended	F 226		

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F 226	Continued From page 31 until the investigation has been completed...9. The Director of Nursing shall ensure the Incident Documentation and Investigation Tool regarding the event is completed unless the event is suspected misappropriation of resident property for which you must use the Misappropriation of Property Investigation Report...12. Results of the investigation related to the resident's incident shall be reported to the Department of Health officials as soon as reasonably possible, in accordance with State and Federal Law..." Review of facility current policy and procedure titled "Reportable Unusual Occurrences," dated 4/1/06, on 2/4/11 at 1:40 p.m., indicated "... Procedure: Occurrences to be reported: Facilities are required by law to report unusual occurrences within 24 hours of occurrence to the Long Term Care Division CFR 483.13(c)(2) states that 'the facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State Law through established procedures (including to the State Survey and Certification Agency." Review of facility current policy and procedure titled "Abuse Prohibition" dated 6/1/10 on 2/4/11 at 1:40 p.m., indicated "...Misappropriation of Resident Property : The deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent..." This Federal tag relates to Complaint IN00084624.	F 226		

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F 226	Continued From page 32 3.1-28(a)	F 226		